New Patient Form – Viva Dental

Office Policy

We appreciate your selection of our dental office to serve your dental needs.

Our goal is to provide the highest quality dental care for you and your family. At the same time, we would like to establish a healthy relationship with our patients by explaining the necessary treatment and associated fees.

By executing this agreement, you are agreeing to pay all services that are received.

We desire to make dental treatment affordable to all our patients. Therefore, we offer the following payment options:

1) Flexible payment plans of up to 6 months upon approval with Care Credit®. Approval must be received prior to the treatment date.

2) Cash, check, or Visa/MasterCard

As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such many routines and necessary dental services are not covered even though you may need those services.

We understand insurance guidelines can be hard to understand and overwhelming at times. Fortunately, with the information provided to us by you and your insurance company we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes the final determination once treatment is completed and the claim is submitted. Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility.

X-Rays: If you have current X-rays from a previous dentist, it is your responsibility to bring those to your appointment. If you do not notify us that you have current films/digital X-rays we will take new ones. Insurance companies have limitations on how often they will pay for X-rays. Therefore, it is important that you let us know if you have had recent ones taken.

Missed Appointments: Your good dental health is our main objective. Therefore, it is extremely important for you to keep all your scheduled appointments. We understand that emergency situations do arise that may require you to change an appointment. As a courtesy to other patients at our office we ask for as much advance notice as possible. If any appointment is failed or cancelled without 48 hours notice a fee of $50.00 will be charged

I realize I am financially responsible for all charges incurred, regardless of insurance coverage. I am responsible for all collection cost incurred by the dental office and a fee of $ 30.00 on any returned check.

All insurance benefits are payable to the dental office, I agree to release any information necessary for the dental office to process claims.

Please fill in the following information. Your answers are for our records only and will be kept strictly confidential subject to applicable laws. Please note that you will be asked some questions concerning your health. This information is vital to allow us to provide you the best care possible.

General Information

First name – Patient _____

Last name – Patient _____

Nick name/ Preferred name _____

Patient birth date MM-DD-YY_____

Gender _____

Marital Status _____

Contact Information

Patient mailing address

_____

City _____

Country _____

Home # _____

Mobile # _____

Work # _____

Ext # _____

Email address

Preferred contact method

Best time to call
* Morning
* Afternoon
* Evening

Dental Information

Do your gums bleed when you brush or floss? Are you currently experiencing dental pain or discomfort?

Are your teeth sensitive to cold, hot, sweets or pressure? Does food or floss catch between your teeth?

Do you have any clicking, popping or discomfort in your jaw? Do you have earaches or neck pain?

Have you had any periodontal (gum) treatment? Do you have any sores or ulcers in your mouth?

Have you ever had orthodontic (braces) treatment? Do you grind your teeth?

Have you had any problems associated with previous dental treatment?

Medical Information

Allergies

*Acetaminophen/Tylenol *Acrylic *Animals *Aspirin *Codeine *Demerol *Erythromycin

*Fluoride *Food *Hay fever/seasonal *Ibuprofen/Motrin *Iodine *Latex *Local anesthetic

*Metals *Morphine *Penicillin *Sulfa *Tetracycline *Other____

Explain_____

Please elaborate on any reactions you have to indicates allergies. _____

Conditions

*Abnormal/excessive bleeding *AIDS or VIH infection *Alzheimer's/dementia * Anemia

*Angina *Anxiety *Arteriosclerosis * Arthritis *Asthma *Autoimmune disease *Back problems

*Blood disease *Blood transfusion *Breathing problems/respiratory disease *Bronchitis

*Cancer/Chemotherapy/radiation treatment *Cardiovascular disease *Chest pain upon exertion

*Chronic pain *Congestive heart failure *Damage heart valves *Diabetes *Eating disorder

*Emphysema *Epilepsy *Fainting spells or seizures *Frequent headaches *G.E. reflux/persistent heartburn *Gastrointestinal disease *Glaucoma *Gout *Hearing difficulties *Heart attack

*Heart murmur *Heart rhythm disorder *Hemophilia *Hepatitis, jaundice, or liver disease

*High blood pressure *Kidneys problems *Low blood pressure *Mitral valve prolapse

*Neurological disorders *Osteoporosis/Paget's disease *Other congenital heart defects

*Pacemaker *Persistent swollen glands in neck *Psychiatric care *Recurrent infections

*Rheumatic fever *Rheumatic heart disease *Rheumatoid arthritis *Severe headaches/migraines

*Severe or rapid weight loss *Sexually transmitted infection (STI) *Sinus trouble *Stroke

*Systemic lupus erythematosus *Thyroid problems *TMJ disorder *Tuberculosis

*Tumor or growths *Ulcers *Other_____

Explain_____

Do you have any disease, condition or problem that is not listed that you think I should know about?
_____

Please indicate if you have or any of the following disease or problems.

*Do you have severe issues with coughing? If yes explain_____

*Have you ever reacted adversely to any medications or injections? _____

*Do you drink alcoholic beverage? If so, frequency of use? _____

*Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If yes, please list approximate date of replacement and any complications. _____

*Has there been any change to your general health within the past year? If yes, what condition is been treated? _____

*Do you use tobacco (smoking, snuff, chew, bidis)? If yes, how interested are you in stopping?
_____

*Have you had a serious illness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problem? _____

*Are you wearing a nicotine patch?

*Are you taking any prescription or over -the-counter medicines? If so please list all, including vitamins, natural or herbal preparations and/or diet supplements. _____

*Do you have sleep apnea?

*Are you pregnant? If yes, numbers of weeks? _____

* Are you nursing?

*Have you ever taken FosaMax, Boniva, Actonel, or other medications containing bisphosphonates?

* Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Name of physician or dentist making the recommendation_____

*Direct billing to your insurance provider on your behalf.